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ABSTRACT

This survey aimed to identify the extent and types of preservice training that Oregon speech-language pathologists received with language-disordered adolescents, and to describe the types of services these clinicians provide. A total of 229 Oregon speech-language pathologists was surveyed, with a response rate of 55% (n=125). Responses showed that 22% had completed a course devoted specifically to adolescent development, and slightly more than half reported some preservice clinical experience with adolescents. The language screening tools most often used by the respondents were informal or clinician-made tests, followed by standardized norm-referenced screening tests. The five language diagnostic procedures most often used were: (1) teacher conferencing and recommendations; (2) "Clinical Evaluation of Language Functions"; (3) informal/systematic observation; (4) semantic, syntactic, and morphologic language sample analysis; and (5) "Test of Adolescent Language." The respondents most often employed the itinerant scheduling model and the one-to-one or small group method for intervention. The use of the intervention approaches of role playing, experiential learning, and curriculum adaptation was nearly equally distributed among respondents. (JDD)

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A SURVEY OF LANGUAGE SERVICES TO ADOLESCENTS IN OREGON PUBLIC SCHOOLS

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A SURVEY OF LANGUAGE SERVICES TO ADOLESCENTS IN OREGON PUBLIC SCHOOLS

INTRODUCTION

Adolescence presents the language disabled individual with difficult and potentially insurmountable challenges (Lipsitz, 1977). Wiig (1984) has argued that language learning disabled students who are deprived of ongoing language services may fail to progress in cognitive, semantic and pragmatic development. She further stated that such a lack of cognitive and linguistic development will interfere with success in all language-based school subjects and vocational training. Donahue and Bryan (1984) have indicated that language handicapped children often operate socially outside their peers. Thus, the very nature of the disability deprives them of the social learning experiences necessary for success during adolescence (Coleman, 1980).

Public Law 94-142 increased language diagnostic and intervention services that were heretofore not available in high schools (Neal, 1986). Blalock (1982) stated that this increase would fulfill an unmet need for language handicapped adolescents. This potential for more adolescents on a clinician's caseload and the unique nature of adolescence as a developmental period required speech-language pathologists to re-evaluate the way this population is served.

Of primary concern to speech-language pathologists was the lack of pre-service training in the physiology, psychology and language development particular to adolescence (D'Alonzo, 1969; Hartzell, 1984; Neal, 1986). Hartzell (1984) stated that in order to adequately serve this age group, speech-language pathologists must have knowledge of three main stages of adolescence that encompass physiological, cognitive and emotional development. Besides specific developmental knowledge, Neal (1984) indicated that speech-language specialists must be familiar with secondary school operations in order to be effective. To further develop competence with these students, Neal (1986) recommended that speech-language pathology training programs include at least one practicum with middle and/or high school students.

The service delivery models used with elementary school children may be inadequate for adolescents. According to Van Hattum (1976), the speech-language pathologist should consider different approaches to scheduling and grouping. The traditional one-to-one or small group model may be inadequate for middle or high school students given the constraints of the school and the needs of the population (Neal, 1986).

Another area that must be addressed is diagnostic and intervention procedures. Boyce and Lord Larson (1983) have developed an approach to serving language handicapped adolescents that includes both assessment and intervention. The

assessment aspect surveys the student's adequacy in social and curricular interactions. Standardized norm referenced language tests are also included. For intervention, "doing" activities are emphasized. Therapy strategies recommended include: 1) role playing different language situations; 2) teaching problem-solving skills; 3) development of functional language skills; and, 4) acquisition of conversational moves.

Shumaker and Deshler (1984) have also recommended a service paradigm specific for language handicapped adolescents. Their system is based on Lewin's (1935) model; where behavior is seen as the result of interaction between the characteristics of the student, the curriculum, the peer group, and other adults. Based on this assumption, the authors stated that the demands of the environment be utilized as the basis for diagnosis. Once the discrepancies between the learner, the curriculum and the social milieu have been identified, then a specific intervention strategy can be designed.

PL 94-142 increased the availability of services to language disordered secondary students. The literature is clear that ongoing intervention is needed with this group to facilitate further cognitive and linguistic growth. Speech-language pathologists have recognized that specialized training with this population is necessary. Two comprehensive models for service delivery have been proposed by different authors. However, minimal information exists on the present state of affairs with regard to the training of speech-language pathologists who serve middle and high school students or the nature of the language programs they offer adolescents.

Thus, the purposes of this survey were to identify the present level of training attained with adolescents by Oregon speech-language pathologists serving this population, and to describe the types of services these clinicians provide. Specific to these, the following research questions were addressed:

1. What types of pre-service training in adolescence did Oregon speech-language pathologists serving adolescents receive?
2. What screening and diagnostic tools are presently used with adolescents in the Oregon public schools?
3. What methods of service delivery and scheduling are presently used with language disabled adolescents in the Oregon public schools?
4. What types of intervention strategies are presently used with adolescents in the Oregon public schools?

METHOD

A list of the Oregon school districts that report 94-142 statistics was obtained from the Oregon Department of Education. Each of those districts was telephoned and the names of the speech-language pathologists who serve students in grades 7 through 12 were obtained. A survey along with a solicitation letter describing the study was mailed to the 229 clinicians identified by their respective districts in the Spring of 1985 (Appendix A).

The content of the survey was developed from a similar instrument used by Lococo in 1983 to describe the services to speech and language handicapped adolescents in the Portland, Oregon area. The format was a check-off type with space provided for open-ended responses in the assessment and intervention sections. The instrument was divided into three parts. The first was focused on degree held by the respondent and education and practicum experience obtained with adolescents. The second requested demographic information, while the third focused on assessment strategies, methods of service delivery and scheduling practices, and approaches to intervention.

RESULTS

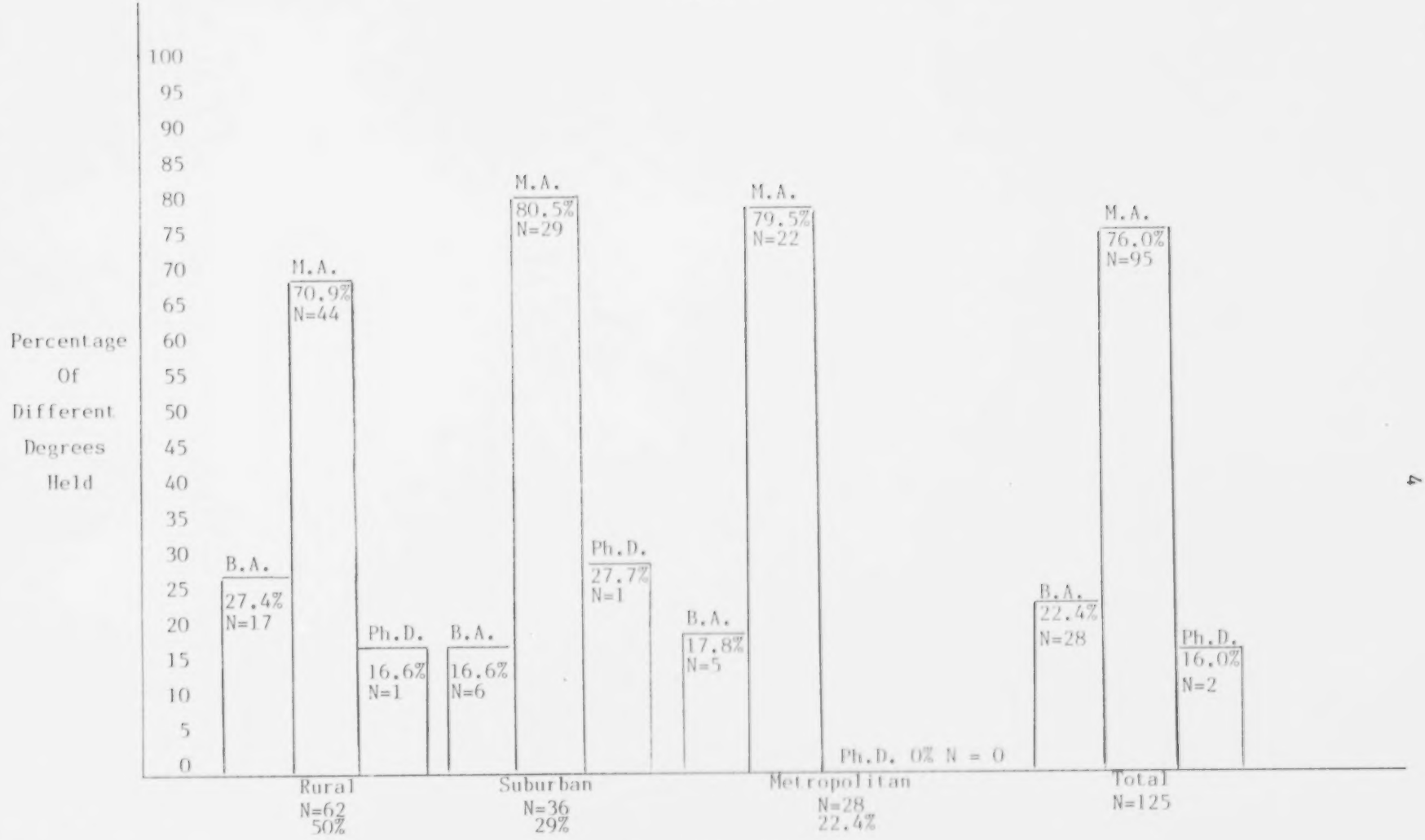
A total of 125 surveys were returned complete, a rate of 55%. Kerlinger (1973) has indicated that a return rate of 50% is adequate for a mail-out questionnaire.

Demographic Data

Respondents were asked to identify the population size of their respective school districts. Three categories were used based on Lococo's 1983 study: 1) metropolitan (above 50,000 population); 2) suburban (between 10,000 and 50,000 population); and 3) rural (less than 10,000 population). Of the 125 surveys received, 62 or 50% were returned from rural school districts. The remaining 50% were split, with 36 or 29% coming from suburban school districts and 28 or 22% from metropolitan school districts.

The academic degree held by the largest number in all three population areas was the Master's, followed by the Bachelor's and the Doctorate respectively. A total of 95 or 76% of the clinicians had a Master's, 28 or 22.4% had a Bachelor's and 2 or 16% had a Doctorate. Thus, the typical respondent had a Master's degree and practices in a rural area. Figure 1 provides a visual summary of these data.

Figure 1



B.A. = Any Bachelor's degree; M.A. = Any Master's degree; Ph.D. = Any doctoral degree

Percentages of Academic Degrees held by Speech-Language Pathologists serving Adolescents in Oregon Public Schools by Population Area and for all Respondents

Education and Training

The first research question was: What types of pre-service training in adolescence did Oregon speech-language pathologists serving adolescents receive? Of the 125 respondents, a total of 79 or 63.2% indicated their educational program included coursework in adolescent development. Of these, 27 or 22% had a class devoted to the psychology and/or physiology of adolescence, and 52 or 42% reported that a portion of one class was on adolescence.

In the areas of language acquisition and language disorders specifically related to adolescents, a subgroup of five or 4% of the total had an entire course in adolescent language acquisition. Five or 4% had an entire class on adolescent language disorders, and 59 or 47.2% indicated that a portion of one class focused on adolescent language problems.

Of the total respondents, 68 or 54.4% had pre-service experience with adolescents. Twenty-eight or 22.4% completed at least one practicum with adolescents, and 40 or 32% had experience with adolescents during student teaching. Table 1 is a summary of the pre-service training data.

Analysis reveals that clinicians practicing with language handicapped adolescents in the Oregon public schools obtained minimal in-depth pre-service academic training with this group. On a positive note, however, at least 42% of the clinicians had some exposure to adolescent development as part of a course, 47.2% had a class that included language problems of adolescents, and 54.4% had some type of clinical experience with adolescents.

Screening and Diagnosis

The second research question was: What screening and diagnostic tools are presently used with adolescents in the Oregon public schools? The survey was subdivided into screening and diagnostic tools. Because some clinicians use more than one of the screening instruments listed, there was a total of 131 responses to this section of the survey.

The screening instrument used by the largest group of clinicians is the informal or clinician-made screening test, with 65 or 50% of the respondents used this. A total of 33 or 25% of the speech-language pathologists used the secondary level of the Clinical Evaluation of Language Functions. A total of 31 or 24% of the

Table 1

Number and Percent of Pre-service Academic and Practicum Experiences
Received by 125 Speech-Language Pathologists Serving Adolescents in the Oregon Public Schools

Number	Percent of Total	Types of Training
79	63.2%	A course or portion of a course focused on adolescent development
27	21.6%	A specific course in adolescent development
52	41.6%	A portion of a course focused on adolescent language acquisition
5	4.0%	A specific course on adolescent language acquisition
64	51.2%	Course work on adolescents with language handicaps
5	4.0%	A specific course on language handicapped adolescents
59	47.2%	A portion of a course focused on language handicapped adolescents
68	54.4%	Clinical experience with language handicapped adolescents
28	22.4%	One practicum with language handicapped adolescents
40	32.0%	Portion of student teaching included experience with language handicapped adolescents

respondents used the Screening Test of Adolescent Language (STAL). A total of 12 or 1.5% used the Adolescent Language Screening Test (ALST).[1] Table 2 is a graphic representation of these data ranked by prevalence of use.

Due to the myriad of potential diagnostic tools at the disposal of the clinician serving adolescents, twenty tests and procedures were listed on the survey to insure adequate coverage. There were 472 responses to this section, indicating clinicians employ more than one procedure or instrument. Although this is a large number, there were five obvious favorites. The tool most often used was teacher conferencing/recommendations, a total of 102 or 22% of the clinicians used this procedure. The others in order of use from second to fifth were the Clinical Evaluation of Language Functions, 86 or 18% of the clinicians; informal/systematic observation, 83 or 17.5% of the clinicians; language sample analysis, 72 or 15.2% of the clinicians; and, the Test of Adolescent Language, 65 or 14% of the clinicians. Table 3 is a rank ordering of all the diagnostic tools in the survey by prevalence.

The third research question was: What methods of scheduling and service delivery are used with language disabled adolescents in the Oregon public schools? A total of 93 or 74.4% of the 125 clinicians responded to statements about scheduling practices. Of this group, 7 or 7.5% used the block method and 86 or 92.4% used the itinerant method. Table 4 is a summary of these results.

The 145 responses to the three statements on service delivery show that a clinician used more than one model. The method that dominated the group surveyed was the individual or small group of two or three students. A total of 102 or 70.3% of those polled used this approach. A small number, 23 or 16%, saw students for a full period in groups of four or more, with 20 or 14% team teaching with a special education or classroom teacher. These data are ranked in Table 5. They show the obvious preference for the one-to-one or small group intervention approach.

The final research question was: What types of intervention strategies are used with adolescents in the Oregon public schools? Three general statements were used to obtain a description of intervention programs in use. An open-ended statement was also provided but was eliminated due to the wide variation of remarks.

There was a total of 221 responses which indicates that more than a single approach to therapy was employed with adolescents. The three methods included were divided fairly equally across the group, 78 or 35.2% used role playing, 77 or 35% used experiential and 66 or 30% used adaptation of the curriculum. Table 6 is a rank ordering of these data by preference, although no one approach emerged as dominant.

[1] The low ranking of the ALST may have been an artifact of a lack of exposure by the practitioners surveyed rather than some inherent problem with the test. The ALST was published just prior to the mailing of this survey.

Table 2

Number, Percent and Ranking of Language Screening Tools
Employed with Adolescents by Oregon Speech-Language Pathologists

N = 131 Responses

Number	Percent	Rank	Screening Tools
65	49.61%	1	Informal or Clinician-Made
33	25.19%	2	Clinical Evaluation of Language Functions Secondary Level Screening Test
31	23.66%	3	Screening Test of Adolescent Language
2	1.52%	4	Adolescent Language Screening Test

Table 3

Number, Percent and Ranking of Language Diagnostic Tools and Procedures Used with Adolescents in the Oregon Public Schools

Tool/Procedure	Number Of Responses	Percentage	Ranking
Teacher Conferencing/Recommendations	102	21.6	1
Clinical Evaluation of Language Functions	86	18.0	2
Informal/Systematic Observation	83	17.5	3
Language Sample Analysis: Semantic, Syntactic, Morphologic	72	15.2	4
Test of Adolescent Language	65	13.7	5
Review of Written Work	52	11.0	6
Fullerton Test for Adolescents	46	9.7	7
Detroit Tests of Learning Aptitude	46	9.7	7
Mean Length of Utterance	25	5.2	8
Test of Written Language	22	4.6	9
Carrow Elicited Language Inventory	22	4.6	9
Developmental Sentence Analysis	11	2.3	10
Token Test - Revised	9	1.9	11
Functional Inventory of Communication Skills	8	1.6	12
Woodcock-Johnson Psychoeducational Battery	7	1.4	13
Brigance Inventory of Essential Skills	5	1.0	14
Loban	5	1.0	14
Length Complexity Index (Miner)	4	.84	15
Tyack/Gottsleben	2	.42	16
Interpersonal Language Skills Assessment	2	.42	16
Total:	472		

Table 4

Type, Number and Percent of Scheduling Methods
Used by Speech-Language Pathologists Serving Adolescents in Oregon

Scheduling Delivery Methods	Number	Percentage
Block Scheduling	7	74.4
Itinerant Scheduling	86	92.4

Table 5

Type, Number, Percentage and Ranking of Service Delivery Models
Used by Speech-Language Pathologists Serving Adolescents in Oregon

Service Delivery Methods	Number	Percentage	Rank
Individual (Up to 3 Clients)	102	70.3	1
Group (4 or more for one period)	23	15.8	2
Team Teach	20	13.7	3
Total:	145		

Table 6

Type, Number, Percentage and Ranking of Intervention Methods
Used with Language Handicapped Adolescents in Oregon

Type	Number	Percentage	Rank
Role Playing	78	35.2	1
Experiential	77	34.8	2
Curriculum Adaptation	66	29.8	3
Total:	221		

DISCUSSION

A total of 125 or 55% of the Oregon speech-language pathologists serving adolescents in the public schools responded to this survey. The purposes of the study were to identify the level of pre-service training attained by Oregon speech-language pathologists with adolescents, and to describe the types of services offered by these clinicians. Research questions were posed in four areas: 1) amount and type of pre-service training in adolescence; 2) screening and diagnostic tools in use; 3) methods of service delivery; and, 4) language intervention strategies.

A relatively small portion of the 125 clinicians, 22%, had a course devoted specifically to development during the secondary years. This trend is also true in the area of language acquisition and language disorders, with only 4% having a class on language acquisition or language disorders in adolescence. Although slightly more than half of the respondents reported some clinical experience with adolescents, only 22.4% had a practicum with adolescents and only 32% spent a portion of their student teaching experience with this population. This inadequate pre-service training in adolescence is an issue that training programs must address.

In order to effectively serve the adolescent population, speech-language pathologists must be adequately prepared at the pre-service level. The ideal training program would include individual courses on adolescent development, language acquisition and disorders in adolescents, and a minimum of one practicum experience with this age group (Neal, 1986).

The language screening tool presently used by a majority of the respondents, 50%, is the "informal or clinician-made," followed by standardized norm referenced screening tests. There may be two related reasons for these results. The first is that administration of a standardized norm referenced screening test is not mandated statewide. The second is that standardized norm referenced screening devices tend to be time consuming to administer.

Twenty different language diagnostic procedures were included in the survey. Of the twenty, the five most often used were "teacher conferencing and recommendations" followed by the Clinical Evaluation of Language Functions, "informal/systematic observation," language sample analysis: semantic,syntactic, morphologic, and the Test of Adolescent Language. The reliance on classroom teacher input and observational data in diagnosis over some of the standardized norm referenced tests may be the result of three factors: 1) the need to compare the client's language to that of the curriculum and the peer group (Boyce & Lord Larson, 1983); 2) the more recent trend toward identifying

pragmatic problems (Donahue & Bryan, 1984); or, 3) the fact that semi-structured situations elicit an increased amount of spontaneous communication (Nidecker, 1980).

The language screening and diagnostic procedures presently in use fit the two service models designed for language handicapped adolescents, in that a combination of observation, teacher interviewing and standardized norm referenced tests are used for assessment. Potentially, clinicians will want to investigate the use of formalized curriculum based assessment in the future.

Speech-language pathologists serving adolescents in Oregon most often employ the itinerant scheduling model, 92.4%, and the one-to-one or small group method for intervention, 70.3%. These results are in contrast to the Boyd and Lord Larson and Shumaker and Deshler intervention models which call for group activities. Speech-language pathologists may be bound to use these two approaches by tradition rather than knowledge of effectiveness.

Because there is no single approach to intervention, the authors identified three broad types: role playing, experiential learning and curriculum adaptation. There was nearly equal distribution of responses for the three methods. The 221 responses to the intervention items lends support to the fact that more than one particular method is used by clinicians. However, specific intervention techniques could not be identified because of the design of the instrument.

The exact nature of language intervention with adolescents remains a mystery. The models provide only general guidelines for structuring a program. Thus, further research needs to be undertaken to identify specific language intervention procedures presently in use.

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APPENDIX A

ADOLESCENT LANGUAGE SURVEY

Return to: Jomar Lococo
Speech and Hearing Sciences
Portland State University
P.O. Box 751
Portland, OR 97207

I. EDUCATION AND TRAINING

Please check those descriptors most characteristic of you education prior to taking you first position as a public school speech pathologist.

A. Degree

_____ Bachelor of Arts/Science

_____ Master of Arts/Science

_____ Doctorate

B. Education and Practicum

_____ I had a specific course in adolescent development (physical and/or psychological).

_____ I had a course that included adolescent development (physical and/or psychological).

_____ I had a specific course in adolescent language development.

_____ I had a specific course in language problems of the adolescent.

_____ I had a course that included language problems of the adolescent.

_____ I completed at least one practicum with the adolescent population.

_____ My student teaching included work with the adoloscent population.

II. PROGRAM DESCRIPTION

Please check those descriptors most characteristic of the program you offer language-learning disabled adolescents in your public school assignment.

A. General Information

I Serve students in these grades at this school:

__7 __8 __9 __10 __11 __12

This school is in a:

_____ rural area (less than 10,000 population).

_____ suburban area (between 10,000 - 50,000 population).

_____ metropolitan area (above 50,000 population).

B. Assessment

I use one or more of these screening instruments regularly

_____ Screening Test of Adolescent Language (STAL).

_____ Wiig-Semel CELF Secondary Level Screening Test.

_____ Adolescent Language Screening Test (ALST).

_____ Informal or clinician made.

_____ Other (specify) _____

I use these norm-referenced instruments regularly:

_____ Clinical Evaluation of Language Functions (CELF).

_____ Fullerton Test for Adolescents.

_____ Detroit Tests of Learning Aptitude.

_____ Test of Adolescent Language (TOAL).

_____ Test of Written Language (TOWL).

_____ Woodcock-Johnson Psychoeducational Battery.

_____ Token Test - Revised.

_____ Briganie Inventory of Essential Skills.

_____ Functional Inventory of Communication Skills.

_____ Interpersonal Language Skills Assessment.

_____ Other (specify)_____

_____ I do a language sample analysis of semantic componer

_____ I do a language sample analysis of linguistic compor (syntax, morphology).

I use these methods/instruments regularly:

_____ MLU

_____ Carrow Elicited Language Inventory (CELI)

_____ Tyack/Gottesleben

_____ Developmental Sentence Analysis

_____ Loban

_____ Length Complexity Index (Miner)

_____ Review of written work

_____ Informal/Systematic Observation

_____ Teacher Conferencing/Recommendations

Please use this space to make comments about specific assessment areas/ instruments mentioned above or other diagnostic methods you use.

Please comment on these or other methods in this space.

Thank you - We appreciate your input!

C. Methods of service Delivery/Scheduling

_____ I use block scheduling at this school.

_____ I use itinerant scheduling at this school.

_____ I see students individually or in small groups of 2 or 3 at this school.

_____ I see students for a full period in groups of 4 or more at this school.

_____ I team teach with Special Ed./Classroom Teacher at this school.

D. Intervention Strategies

_____ I use role-playing in my sessions.

_____ I use adapted curriculum content in my sessions.

_____ I favor an experiential approach to intervention.

_____ I use a specific language program (specify) _____